

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTMEBER 18, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed outpatient second Lumbar Facet Injection under fluoroscopy with intravenous sedation to the bilateral L3-4, L4-5, L5-S1 levels

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Amount Billed	IRO Decision
724.8, 729.5	Lumbar Facet Injection under fluoroscopy with intravenous sedation to the bilateral L3-4, L4-5, L5-S1 levels		Prosp	1		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-20 pages

Respondent records- a total of 55 pages of records received from the URA to include but not limited to: TDI letter 8.29.12; Request for an IRO forms; letters 7.9.12-8.2.12; Pre-Authorization form 7.25.12; records, 3.27.12-7.16.12; 6.5.12; MRI Rt Knee 4.11.11; X-ray Abdomen 4.11.11

Respondent records- a total of 181 pages of records received from to include but not limited to: Request for an IRO forms; letters 7.10.12-8.2.12; letter 5.19.11; MRI Rt knee Report 4.11.11, X-ray Report 4.11.11, FCE 1.11.12; records 2.2.11; records 2.14.11-2.23.12; records 2.17.11-3.23.11; records 4.14.11-5.26.11; report 6.16.11; records 2.6.12-2.21.12; 3.27.12-7.16.12; Report 6.5.12; MRI Rt Knee 4.11.11; X-ray Abdomen 4.11.11; DDE 6.28.11, 2.28.12

Requestor records- a total of 86 pages of records received to include but not limited to: TDI letter 8.29.12; Request for an IRO; letters 7.10.12-8.2.12; Pre-Authorization form 7.25.12; records, 3.27.12-8.20.12 Report 6.5.12; MRI Rt Knee 4.11.11; X-ray Abdomen 4.11.11; 6.6.11; records 12.12.11-2.23.12

PATIENT CLINICAL HISTORY [SUMMARY]:

The records presented for review include an MRI of the knee which noted a medial meniscus tear and a sprain of the anterior cruciate ligament. Plain films of the abdomen were normal. There was a noted osteoarthritis of the knee.

In June of 2011, an evaluation noted a reflex sympathetic dystrophy of the right lower extremity and medial meniscus tear. A knee arthroscopy was completed. Subsequent to the arthroscopy, lower extremity pain was noted in this 5'7" 275 pound gentleman.

The January of 2012 note indicated complaints of chronic low back pain. Muscle spasms and tenderness over a generalized area and non-specific to the facet region were noted. noted a piriformis syndrome. The February note indicates that the injury was limited to the knee alone.

In March of 2012, completed an evaluation and noted that there was chronic right knee and low back pain. A reflex sympathetic dystrophy was noted and the past medical history was significant for heart disease, diabetes, and hypertension. The physical examination noted facet joint tenderness with extension. A follow-up physical examination noted a positive straight leg raising for hamstring tenderness. In April of 2012, the pain was noted over the facet joints and SI joints. Three level facet joint injections were performed in June of 2012. Significant pain reduction was noted.

Repeat three level injections were not certified. Reconsideration was also non-certified. took exception to the determination. The most current physical examination findings now report tenderness over the facet joints alone (contrary to what was initially reported).

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines, a series of blocks is not supported. Nor is the notion that more than two levels are to be addressed. The level of pain response was not noted to be more than 70% as required. While noting that some pain relief was achieved, the standards listed in the Division mandated Official Disability Guidelines were not met. Therefore, given that the request was for more than two levels and the amount of pain relief was not documented to be more than 70%, this request cannot be endorsed.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)